DCH/LOP-030 (05/04)

Michigan Department of Community Health
Board of Optometry
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

OPTOMETRY LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Optometry. Questions regarding your application can be directed to the Michigan Board of Optometry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee will be returned.

GENERAL INSTRUCTIONS

Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Sign and date your application. Failure to correctly complete the application in its entirety may delay the processing of your application. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

APPLICANTS FOR LICENSURE BY EXAMINATION MUST SUBMIT:

1. A completed application and proper fee.

2. A final, official transcript sent directly from your school that shows the date your doctor of optometry degree was conferred.

3. Applicants are required to have passed Parts I, II and III of the National Board of Examiners in Optometry (NBEO) examination. Request the NBEO (www.optometry.org) to send your examination scores directly to this office.

4. After your application and fee are received in the Board office, you will be sent a Michigan Laws and Rules Examination. This must be successfully completed and returned to our office before your license will be issued.

5. Submit the attached controlled substance application with the $85.00 fee. A controlled substance license is required for every licensee who manufactures, distributes, prescribes or dispenses any controlled substance in Michigan.

APPLICANTS FOR BY LICENSURE BY ENDORSEMENT: (You must hold a current license in another state to apply for licensure by endorsement.)

If you have been licensed in another state for at least 5 years, you must submit:

1. A completed application and appropriate fee.

2. Verification of licensure from any state where you hold or have ever held a permanent optometrist license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

3. After your application and fee are received in the Board office, you will be sent a Michigan Laws and Rules Examination. This must be successfully completed and returned to our office before your license will be issued.

4. Submit the attached controlled substance application with the $85.00 fee. A controlled substance license is required for every licensee who manufactures, distributes, prescribes or dispenses any controlled substance in Michigan.

If you have been licensed in another state less than 5 years, you must submit:

1. A completed application and appropriate fee.

2. A final, official transcript sent directly from your school that shows the date your doctor of optometry degree was conferred.

3. Overall passing scores on parts I, II and III of the National Boards must be sent directly from NBEO (www.optometry.org).

4. Verification of licensure from any state where you hold or have ever held a permanent optometrist license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

5. After your application and fee are received in the Board office, you will be sent a Michigan Laws and Rules Examination. This must be successfully completed and returned to our office before your license will be issued.

6. Submit the attached controlled substance application with the $85.00 fee. A controlled substance license is required for every licensee who manufactures, distributes, prescribes or dispenses any controlled substance in Michigan.

APPLICANTS SEEKING DIAGNOSTIC PHARMACEUTICAL AGENTS (DPA) AND THERAPEUTIC PHARMACEUTICAL AGENTS (TPA) CERTIFICATION MUST SUBMIT:

1. The completed application and appropriate fees.

2. A copy of your certificate showing successful completion of a course in advanced cardiac life support or a course in basic life support.

3. Complete the Management and Emergency Plan form and make a photocopy of it to be kept permanently in your office. Submit the original, signed plan with the application.

4. The Verification of Diagnostic Pharmaceutical Agents (DPA) Training Form. Section I of the Verification of Diagnostic Pharmaceutical Agents (DPA) Training form must be completed by the applicant. Section II of this form must be completed and returned to this office by the Director of the DPA educational program or the Registrar of the institution where the training was completed.

5. The Verification of Therapeutic Pharmaceutical Agents (TPA) Training Form. Section I of the Verification of Therapeutic Pharmaceutical Agents (TPA) Training form must be completed by the applicant. Section II of this form must be completed and returned to this office by the Director of the TPA educational program or the Registrar of the institution where the training was completed. **YOU MUST HAVE DPA CERTIFICATION TO OBTAIN TPA CERTIFICATION**.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Optometry in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Optometry in writing to request a refund.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

DCH/LOP-010 (05/04)

Michigan Department of Community Health
Board of Optometry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR LICENSURE AS AN OPTOMETRIST

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

- ☐ **License by Examination Fee: $170.00 71-4901-01**
- ☐ **License by Endorsement Fee: $120.00 71-4901-09**
  (Must Currently be Licensed in Another State)
- ☐ **Diagnostic Pharmaceutical Agents (DPA) Certification Fee: $75.00 71-4901-11**
  in addition to the license fee above.
- ☐ **Therapeutic Pharmaceutical Agents (TPA) Certification Fee: $75.00 71-4901-11**
  in addition to the license and DPA Certification fees above.
  (DPA CERTIFICATION REQUIRED TO OBTAIN TPA CERTIFICATION)

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Have you ever held a health professional license in Michigan?

☐ No ☐ Yes

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. **Have you ever been convicted of a felony?**	☐ **Yes**	☐ **No**
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?**	☐ **Yes**	☐ **No**
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?**	☐ **Yes**	☐ **No**
4. **Have you been treated for substance abuse in the past 2 years?**	☐ **Yes**	☐ **No**
5. **Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?**	☐ **Yes**	☐ **No**
6. **Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?**	☐ **Yes**	☐ **No**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

7. Have you ever had a federal or state optometrist license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Do you hold or have you ever held an optometry license in any state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). **You must have each state board verify licensure directly to this board office. (Attach additional sheet** ☐ Yes ☐ No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your optometry education. Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree

FOR ENDORSEMENT APPLICANTS ONLY

Provide a description of your professional optometry experience. Attach additional sheets if necessary.

Have you been engaged in clinical practice, teaching at a school of optometry, or research related to the field of optometry? If Yes, complete the section below for a minimum of five years of experience starting with the most recent date.

☐ Yes ☐ No

Name and Address of Employer	Dates of Practice From	To	Duties

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

DCH/LOP-022 (05/04)

Michigan Department of Community Health
Board of Optometry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

MANAGEMENT AND EMERGENCY PLAN

This is a sworn statement
Authority: Public Act 368 of 1978, as amended

Type or Print Only

Optometrist's Name		
Street Address		
City	State	ZIP Code
Permanent I.D. Number	Date of Plan Completion	

REFERRALS: List the names and addresses of a least three physicians (M.D. or D.O.), physician clinics, or hospitals in Michigan to whom you will refer patients with adverse drug reactions. Be sure at least one is skilled or specializes in the diagnosis or treatment of the eye (board eligible or certified ophthalmologist). An optometrist may include the patient's primary care physician in the plan, but shall not substitute the patient's primary care physician for a physician named in the plan who specializes in the diagnosis and treatment of diseases of the eye.

Name of Ophthalmologist	Telephone
Address	City,State, Zip

Name of Second Referral	Telephone
Address	City,State, Zip

Name of Third Referral	Telephone
Address	City,State, Zip

PLAN: The following management plan will be in operation in my office:

1. **I will refer patients with an adverse drug reaction to appropriate medical specialists or facilities.**
2. **I will routinely advise each patient, and so note in their record, to contact me if the patient experiences an adverse drug reaction.**
3. **I will place information in each patient's permanent record describing any adverse drug reaction experienced by the patient, and the date and time any referral was made.**
4. A COPY OF THIS MANAGEMENT AND EMERGENCY PLAN WILL BE KEPT IN MY OFFICE.

Signature of Applicant	Date

DCH/LOP-024 (05/04)

Michigan Department of Community Health
Board of Optometry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

VERIFICATION OF THERAPEUTIC PHARMACEUTICAL AGENTS (TPA) TRAINING

Authority: Public Act 368 of 1978, as amended

SECTION I - APPLICANT INFORMATION

Applicant Please complete the information in Section I and mail this form to the school of Optometry where you trained in the didactic and clinical use of therapeutic pharmaceutical agents (TPAs).

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Applicant's Signature		Date

SECTION II - VERIFICATION OF TRAINING

School of Optometry The applicant listed above is seeking certification to use and prescribe TPA's in Michigan. Please complete Section II and the certification below concerning training received by the applicant. When the form is complete, mail it directly to the Board of Optometry at the address shown above.

Name of School	Telephone Number
Street Address	
City / State / ZIP Code	
Dates of Training **From:** **To:**	

CERTIFICATION

I certify that the applicant named above has completed a minimum of 10 quarter hours or 7 semester hours of credit or 100 classroom hours of study, in courses relating to the didactic and clinical use of therapeutic pharmaceutical agents related to optometry.

_____ _____

Authorized Signature (Dean, Registrar, etc.) **Date**

_____

Type or Print Name and Title

(S C H O O L S E A L)

DCH/LOP-021 (05/04)

Michigan Department of Community Health
Board of Optometry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

VERIFICATION OF DIAGNOSTIC PHARMACEUTICAL AGENTS (DPA) TRAINING

Authority: Public Act 368 of 1978, as amended

SECTION I - APPLICANT INFORMATION

Applicant Please complete the information in Section I and mail this form to the school of Optometry where you trained in the use of topical ocular diagnostic pharmaceutical agents (DPAs).

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Applicant's Signature		Date

SECTION II - VERIFICATION OF TRAINING

School of Optometry The applicant listed above is seeking certification to use topical ocular DPAs in Michigan. Please complete Section II and the certification below concerning training received by the applicant. When the form is complete, mail it directly to the Board of Optometry at the address shown above.

Name of School	Telephone Number
Street Address	
City / State / ZIP Code	
Dates of Training **From:** **To:**	

CERTIFICATION

I certify that the applicant named above has completed a minimum of 60 classroom hours in general and clinical pharmacology with not less than 30 of the 60 classroom hours of the course of study being allocated to ocular pharmacology and emphasizing the systemic effects of, and reactions to, topical ocular diagnostic pharmaceutical agents, including the emergency management and referral of any adverse reactions that may occur.

The doctor named above has also successfully completed an examination with a score of 75% or better on general and ocular pharmacology as it relates to the practice of optometry, with particular emphasis on the use of topical ocular diagnostic pharmaceutical agents, including emergency management and referral of any adverse reactions that may occur.

_____ _____

Authorized Signature (Dean, Registrar, etc.) **Date**

_____ (S C H O O L S E A L)

Type or Print Name and Title

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (12/05)

Board Use Only
Date of Licensure
License Number

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you just prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: **Initial (first time) professional license or relicensure of your professional license - $85.00. If you already hold a professional license and your professional license expires in:**

0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

Street Address	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐	or	☐
☐ 51 - 01 D.O. 71-5315	☐	or	☐
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

☐ **Yes** ☐ **No**

If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**

☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.